Confluent Lichen Nitidus with Lesions on the Tongue.

By H. W. Barber, M.B.

Mrs. S. P., aged 59, kindly referred to me by Dr. Semon, whom she consulted in July, 1926, regarding a generalized eruption, which appeared first on the wrists and gradually spread. White streaks on her tongue had appeared at about the same time.

Family History.—Father died, aged 65, of ? "galloping consumption." Mother died aged 95. She has one son and daughter living and well; one child, aged nine months, died from meningitis.

January 31, 1927.—When I first saw the patient the eruption was evidently slowly disappearing. At that time there was an extensive eruption of lichen nitidus of the confluent type with the following distribution :—

Wrists and Forearms.—Confluent patches, evidently fading, on the extensor surfaces of the forearms, particularly the right—infiltrated scaly patches in which the primary papules were in places indistinguishable.

Antecubital Fossæ.—Diamond-shaped patches of close-set papules tending to become confluent.

Neck.—Large area encircling the neck extending up to the hair on the nape, down to the clavicles, and involving the V-shaped area on the manubrium sterni.

Submammary Regions and Abdomen.—Eruption spreads across the mid-line from under both breasts and down to the umbilicus. On the lower abdomen, numerous discrete papules extend out to the flanks and down to the groins.

Back.—Practically free, except between the nates.

Popliteal Spaces.—Closely-set papules as in the antecubital fossæ; a few discrete papules on the inner side of the knees.

Mucous Membranes.—On the tongue are two symmetrical white streaks, and white patches on mucous membrane of the cheeks; formerly white patches on the inner surface of the *lower lip* according to the patient's statement. No sign of the eruption on the vulva.

A biopsy was made on the left forearm, on the outer side of the antecubital fossa. The typical appearances of lichen nitidus are seen in the serial sections submitted.

The great interest of this case is the presence of lesions in the mucous membrane of the mouth, which resemble the appearances of lichen planus in this situation. Dr. Civatte is inclined to consider lichen nitidus as a variety of lichen planus, and has shown me sections from a case in which typical lichen planus and lichen nitidus were both present: in this case there were lesions in the mouth histologically characteristic of lichen planus.

The clinical and histological appearances of lichen nitidus are so definite, and the involvement of the antecubital and popliteal spaces in the confluent type of case so constant, that I feel sure it is a clinical entity distinct from lichen planus. I am satisfied from a careful study of a long series of cases that it is not, as Chatellier suggests, a tuberculide.

Discussion.—Dr. A. M. H. Gray said that this case resembled one described as miliary lichen planus by Dr. Maloney, who differentiated it at some length from lichen nitidus. There was a type of lichen planus in which the differentiation was very difficult. He (Dr. Gray) thought the appearance of the section now shown more like planus than nitidus; the infiltration was flat, whereas in nitidus it was round and deeper in the epidermis than this section showed. Further, there was not, usually in nitidus, that marked thickening of the granular layer. The lesions in the mouth were like lichen planus lesions.

Dr. BARBER (in reply) said that, not knowing the cause, he had no rational treatment to offer, but small doses of iodine seemed to cure the itching and to hasten involution of the lesions.

With regard to the histology, he had collected many serial sections from a number of these cases. Clinically, he regarded the present case as typical lichen nitidus. On looking at the discrete papules—best seen on the lower abdomen—and at the condition in the antecubital fossæ and popliteal spaces, it would be agreed, he thought, that no other diagnosis was possible.

With regard to the microscopical sections, in this case the appearances were not so typical as in other cases he had had of the condition, the reason being that in the section he was now showing there was marked hyperkeratosis over the nodule. Though such hyperkeratosis might occur, as McDonagh had pointed out, it was not usually so definite as in the present case. The thickening of the granular layer referred to was more evident than was usual in lichen nitidus. But even in these sections one saw the apparent eating away of the epidermis by the lichen nitidus infiltration, which was not seen in lichen planus. In lichen planus the epidermis was thickened (acanthosis).

Lupus Erythematosus of the Scalp, associated with Scars of Old Papulo-Necrotic Tuberculide Lesions and of Erythema Induratum on the Arms and Legs.[1]

By H. W. BARBER, M.B.

MRS. C. P., aged 41.

Personal History.—When an infant patient had an operation for enlarged cervical glands; the scar is still present. At the age of 19 she again had enlarged cervical glands, and at this time there were recurring cutaneous lesions on the arms and legs. The lupus erythematosus of the scalp has been present for about four years.

Present Condition.—A well-marked chilblain-circulation, skin of arms and legs being bluish, even when she is at rest in bed; face also dull bluish-red; numerous staphylococcal pustules on the rosaceous area.

On the *forearms*, particularly around the elbows, and extending down the ulnar border, are numerous pitted scars of varying size, suggestive of a former eruption of papulo-necrotic tuberculide.

On the *legs*, around and below the knees, are similar scars, and above the ankles larger ones, suggestive of the deeper subcutaneous lesions of erythema induratum.

On the *scalp* there is an extensive eruption of lupus erythematosus.

Numerous hard discrete glands are palpable in both triangles of the neck.

On admission to hospital the patient had very severe oral sepsis, which has been treated.

Wassermann reaction: Negative.

Complement-fixation Test for Tubercle: Negative.

Von Pirquet Reaction (Dr. Eyre): 64 per cent. + +, 16 per cent. +, 4 per cent. *nil*, 1 per cent., *nil*.

X-ray Examination of the Chest shows calcified nodules at the apex of the right lung and increased fibrosis at the right root.

This case might be cited in favour of the tuberculous origin of lupus erythematosus, but it should be remarked (1) that both lupus erythematosus and the papulo-necrotic tuberculide eruptions occur chiefly in persons with a chilblain-circulation, and their co-existence in the same person, which is not very common, does not necessarily indicate that they are due to the same infection; (2) that in this patient the tuberculide lesions occurred when the tuberculosis of the cervical

[1] This case should be compared with one shown by Dr. Dowling at the last Meeting of the Section.